USE OF THIS MANUAL

The *Fee-For-Service Provider Billing Manual* is a publication of the Arizona Health Care Cost Containment System's (AHCCCS) Claims Department of the Division of Fee-for-Service Management. The Claims Department also publishes *Claims Clues* as a supplement to this manual.

Questions or comments related to this manual should be directed to:

The AHCCCS Claims Policy Unit
701 E. Jefferson Mail Drop 8000
Phoenix, AZ 85034

This manual also is available online at:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html.

Any updates to the manual will be posted on the AHCCCS website and available to providers for viewing. Any updates will also be listed at the bottom of each, individual chapter, under the Revision History section, so that providers may see, at a glance, what the most recent updates to each chapter are.

This manual contains basic information concerning AHCCCS, Arizona's Medicaid Program (Title XIX), KidsCare and Arizona's SCHIP Program (Title XXI). The intent of this manual is to furnish providers' billing staff and contracted billers with information about AHCCCS, coverage of specific services, and requirements for the completion of Fee-For-Service claims that are submitted to the AHCCCS Administration. Additional requirements are found in AHCCCS regulations, the Provider Agreement, and the Claims Clues publications.

Physicians, hospital administrators, and other medical professionals may only be interested in reviewing chapters pertaining directly to their specialty, in addition to chapter 1of this manual. However, providers' office staff/billers should become familiar with the requirements for member eligibility and enrollment, prior authorization requirements, and billing policies and procedures. Use of the manual will help reduce questions and expedite the claims process by ensuring that claims are filed correctly the first time.

This manual provides guidance for **Fee-For-Service claims *only*** and it is **not** intended as a substitute or a replacement for a health plan's or a program contractor's billing manual. If you contract with and/or provide services to members enrolled with an AHCCCS health plan or program contractor, please continue to follow their instructions when providing and billing for services rendered to a member enrolled with that health plan or program contractor.

Note: The covered services, limitations, and exclusions described in this manual are global in nature and are included to offer general guidance to providers. The *AHCCCS Medical*

Policy Manual (AMPM) contains more specific information about covered services, limitations and exclusions, and is available on the AHCCCS website at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/.

AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System (AHCCCS) was implemented on October 1, 1982, as the nation's first statewide indigent health care program designed to provide services to eligible persons primarily through a prepaid capitated managed care system. Operating as a demonstration project under the federal Medicaid program, AHCCCS receives federal, state and county funds to operate, plus some monies from Arizona's tobacco tax.

The Arizona Long Term Care System (ALTCS) was implemented December 19, 1988, for the developmentally disabled and on January 1, 1989, for the elderly and physically disabled. ALTCS provides institutional care and home and community based services to individuals who meet financial eligibility requirements and are at risk of institutionalization.

AHCCCS enrolls most eligible persons with acute care health plans and long term care program contractors. The health plans assume responsibility for the provision of all acute care covered services to enrolled members. The program contractors are responsible for providing and managing acute health care, behavioral health care, and long term care services for ALTCS members.

NOTE: In this manual, the term "member" is used to describe an AHCCCS or ALTCS eligible individual who may be either Fee-For-Service or enrolled with a health plan or program contractor. The term "contractor" refers to both health plans and program contractors.

The contractors also are responsible for reimbursing providers for services rendered to eligible members during the prior period coverage (PPC) time frame that precedes the actual posting of enrollment with a contractor. The PPC period extends from the beginning date of an AHCCCS member's eligibility to the date prior to the member's date of enrollment with a contractor.

AHCCCS reimburses providers for services in only two ways:

1. Contractors receive a prepaid capitation payment each month to cover services provided to their enrolled members and members covered under PPC. The contractors then directly reimburse providers who subcontract with them or provide services to their enrolled members.
2. AHCCCS reimburses providers on a Fee-For-Service basis for services rendered to members eligible for AHCCCS or ALTCS, who are not enrolled with a contractor or covered under PPC.

In limited situations, AHCCCS is authorized to reimburse members.

AHCCCS FEE-FOR-SERVICE POPULATIONS

The Fee-For-Service populations include the following groups:

- Members in the Federal Emergency Services (FES) program,
- Members enrolled in Indian Health Services (IHS), and
- On-reservation Native Americans enrolled with a tribal contractor.

AHCCCS FEE-FOR-SERVICE PROVIDERS

The provider's primary role is to render medically necessary services to AHCCCS members. Prior to billing for services, the provider must be an active registered provider with AHCCCS. Providers may elect to only provide services to AHCCCS Fee-For-Service members or may subcontract with one or more contractors to provide services to enrolled members.

NOTE: The provider **must** be registered with AHCCCS in order to receive payment for any services provided from **either** AHCCCS or any contractor.

AHCCCS-COVERED SERVICES

AHCCCS provides coverage for medically necessary services furnished to Fee-For-Service members by registered AHCCCS providers. AHCCCS covered services are outlined for each Fee-For-Service population as follows:

Coverage of services falls into two broad categories: AHCCCS Acute Care and AHCCCS Long Term Care System (ALTCS).

AHCCCS Acute Care

- Preventive and Acute Medical Care Services
- Behavioral Health Services
- Limited Rehabilitative Services, Home Health Care, and Nursing Home Care

AHCCCS Acute Care offers preventive, acute, and behavioral health care services with limited coverage of rehabilitative services, home health care and long term care, as specified in A.A.C. Title 9, Chapter 22, Articles 2 and 12.

Acute care services covered under Title XXI, the State Children's Health Insurance Program (also known as KidsCare), are specified in A.A.C. Title 9, Chapter 31, Articles 2, 12, and 16.

AHCCCS Long Term Care System (ALTCS)

- Preventive and Acute Medical Care Services
- Behavioral Health Services
- Long Term Care Institutional Services
- Alternative Residential Living Services
- Home and Community Based Services
- Speech, Physical, Respiratory, and Occupational Therapies
- Nursing services for ventilator dependent individuals residing at home

AHCCCS Long Term Care services are covered more extensively in the ALTCS regulations, as specified in A.A.C. Title 9, Chapter 28, Articles 2 and 11.

Note: Out-of-state services are covered as provided for under 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical covered.

Medical Necessity

Medical necessity may be determined through a professional review for appropriateness of services provided in conjunction with established criteria related to severity of illness and intensity of services. Documentation submitted by providers is key to the determination of medical necessity. Failure to submit documentation that substantiates medical necessity may result in denial of reimbursement.

Utilization Management

Payment for services is subject to AHCCCS rules, the Provider Agreement, policies and requirements, including, but not limited to the following Utilization Management functions:

- Prior Authorization
- Concurrent Review
- Medical Claims Review
- Post-Payment Review
- Special Consent Requirements

Contact Telephone Numbers

Please see Exhibit 1-4 for a quick reference to important telephone numbers.

REVISION HISTORY

Date	Description of changes	Page(s)
12/22/2017	Formatting	All